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PHM/SR9-53 (RB4)

VIOLENCE

AS A PUBLIC HEALTH ISSUE

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VIOLENCE AS A PUBLIC HEALTH ISSUE

Coordinated by: Tathapi Trust: Audrey Fernandes

Also available in Marathi: Translation by Medha Kale
Special inputs: Dutta Desai & Vinaya Deshpande

Also available in Flipchart format: Marathi & English

Produced by: Tathapi Trust, for Jan Arogya Abhiyan
425, DP, 77 Mukund Nagar, TMV Colony,
Pune 411 037
Email: tathapi@vsnl.com

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This booklet and flipcharts have been produced for the 'Jan Arogya Abhiyan' campaign on Violence as a Public Health Issue in Maharashtra. It is the collective effort of many of the member organisations of the Jan Arogya Abhiyan, (Masum, Tathapi, Cehat, Alert-India, BGVS, Forum for Women's Health) and Friends for Victims of Torture (a network of forensic doctors). It has incorporated suggestions from the JAA workshop (May 6, 2001, Pune) and meeting (September 14-15, 2001, Mumbai) where the flipcharts were presented.

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Introduction

Violence is widespread. It contributes very highly to illness episodes and results in poor quality of life. Violence that women face is closely linked to their social status. It affects their health status as well. Up to now, all violence was seen as only a law and order problem. However, recent attention has been to focus on its implications on health. The morbidity and mortality resulting out of violence on women forms a large burden on the public health services as well. There is a need for health professionals to develop an integrated approach to deal with cases of violence.

Women who are victims of violence do not easily come forward and speak out, nor do they seek help. However, they almost always visit a health facility to seek relief for their pain. By bringing to the fore the inter-linkages between violence as a health problem, a social problem and a law and order problem an integrated approach to tackle violence could be designed to ensure that the individual woman receives justice, as well as to prevent the epidemic proportions of violence in our society.

The *Jan Arogya Abhiyan* has taken up a campaign to introduce this facet of public health among professionals and health workers working in the public and private health sector of Maharastra.

The Jan Arogya Abhiyan

The Jan Arogya Abhiyan (JAA) is a network of people's science organisations, Health NGOs, and women's organisations, trade unions etc. The network campaigns for health rights and better public health services. The campaign is seen in the background of structural adjustment and privatisation programmes and politics being undertaken since 1991 by the Government. The JAA adopts the Alma Ata declaration (1978) definition of health and takes an integrated approach to health and development.

"Health is a state of complete physical mental and social well being and not merely the absence of disease"

Alma Ata Declaration, 1978

The JAA, Maharashtra, has taken up issues, since June 2000, of making the public system more people oriented and accountable at the village level, opposing population policy etc. Among its various concerns, the JAA has also focused on women and health concerns.

The issue of violence as a public health issue has also arisen out of the work done by some of the health NGOs (CEHAT, MASUM) working in this area. JAA in turn has felt the need to take violence on women to the larger audience for awareness and education.

The Flip Charts

Background: The flip charts are the result of concern about the alarming number of deaths due violence among women in Maharashtra. They have been conceived and prepared for and by the Jan Arogya Abhiyan. They are to be an orientation tool primarily for Medical Officers at PHCs, and otherwise for all health personnel, including private doctors.

The Campaign: At a dialogue initiated by the Jan Arogya Abhiyan, Maharashtra with the Director General of Health Services, willingness was shown to address this issue within the health services. We hope that this orientation booklet will act as a catalyst to initiate concrete steps by the Health Services to bring to the open, gender based violence, and especially domestic violence in Maharashtra.

The Flip-charts are an orientation tool for Medical Officers and health workers, in Maharashtra. Facing each chart is a highlight of the issue that is the focus of the chart. There are 14 charts. It is expected the activist/ resource person taking the session would acquaint themselves with each chart and the points to be highlighted in each chart before the session.

The points that we are attempting to highlight through the flip charts are -

- **Gender-based violence is widespread**. Domestic violence is particularly endemic and not the problem of an individual household.
- Gender-based violence forms a **large burden on the existing health system**.
- We are trying to highlight the **gender blindness** in the health system by emphasising that gender-based violence is a health issue. Though the percentage of female lives claimed in accidents due to burns, drowning etc, as is comparable to that of men's lives claimed in road accidents,(15-44 age group) the PHC Manual for doctors mentions only health education for safe driving norms. These female deaths are simply ignored by the health system.
- **Care needs to be taken with the disclosure of illnesses** such Sexually Transmitted Diseases/ HIV/ AIDS/ Tuberculosis etc., to women patients. Disclosing this to family members may itself result in violence or in abandoning of the patient. Doctors and health professionals need to be more sensitive to a woman's social situation and status. This is necessary both to ensure that treatment

and follow-up is as prescribed and does not result in violence itself.

- This is a tool to generate a more **in depth discussion on violence**. It could be discussed more as a preventive measure in panchayats, with women elected and non-elected (stood for elections but failed) members. It can also be discussed as a curative measure. Medical Officers can make contact and network with Mahila Mandals and Women's organisations and vice versa to tackle cases of violence.
- **Orientation of all health workers** is also necessary in order to make the PHC a sensitive place a woman can go to. This orientation also needs to be taken at the PHC level for all PHC staff as well.

The flip charts have been structured through discussion among the many organisations and individuals who are part of JAA. They are designed to convey the most in the smallest amount of time. The charts are listed below:

- Mortality of Women in Maharashtra aged 15-44
- Violence forms a large burden of illness
- Child sex ratio in Maharashtra
- The case of Tara- a burns victim
- The case of Sonubai- mental illness
- The case of Manda - disclosing STDs/ RTIs
- The case of Kamalabai- the doctor intervenes
- Understanding Gender Violence
- What are the Health consequences of Violence?
- When are Women most vulnerable to Violence?
- What is the Role of the Medical Officer?
- How can we identify cases of violence?
- At what levels can we work to combat violence?
- We need to work together

The booklet:

In this booklet we first present the flip charts. Then a brief orientation/ perspective note on violence as a public health issue with specific orientation to Maharashtra has been included. We thought it was necessary to elaborate on some of the points that have been brought up in the Flip-charts. We also felt that addressing violence from a public health angle is 'new' for many activists working in violence and gender issues, as well as for those working in health.

Wherever necessary, there is specific reference to the flip charts. It will also enable those who wish to conduct this orientation with Medical Officers, and Health Workers to get an overview of the issues involved.

The largest single cause of death among women in the reproductive age group (15-44 years) is violence.

In the same age group, deaths by other causes are:

TB-	9.58%
Childbirth and pregnancy related causes-	6.00%
Non-Pregnancy Anaemia-	3.48%
Heart Diseases-	9.82%
Cancer-	7.36%

These figures reveal that gender linked violence is high. Gender discrimination is a question that needs to be addressed within the health services as well.

Accidents are a major cause of deaths among men as well. These, however, fall largely in the category of 'road accidents'. On the other hand, the most dangerous place for a woman is her home!

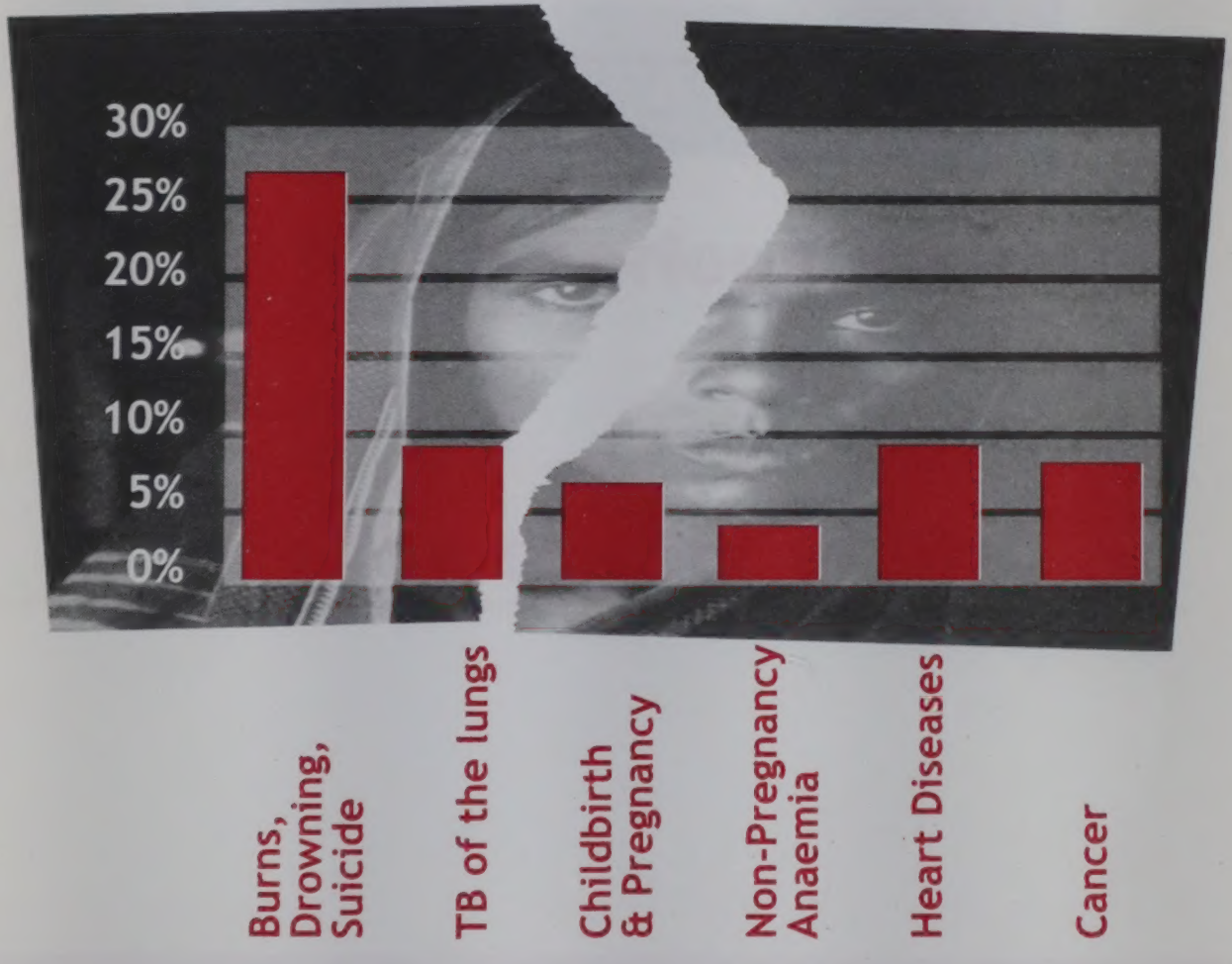
In Maharastra the single largest cause of death among women aged 15-44 is burns.

When burns (15.05%) is clubbed with deaths due to suicides (6.41%)

homicides (0.47%), drowning (4.5%) this percentage

*jumps to **26.3% of all deaths** in the reproductive age group 15-44.*

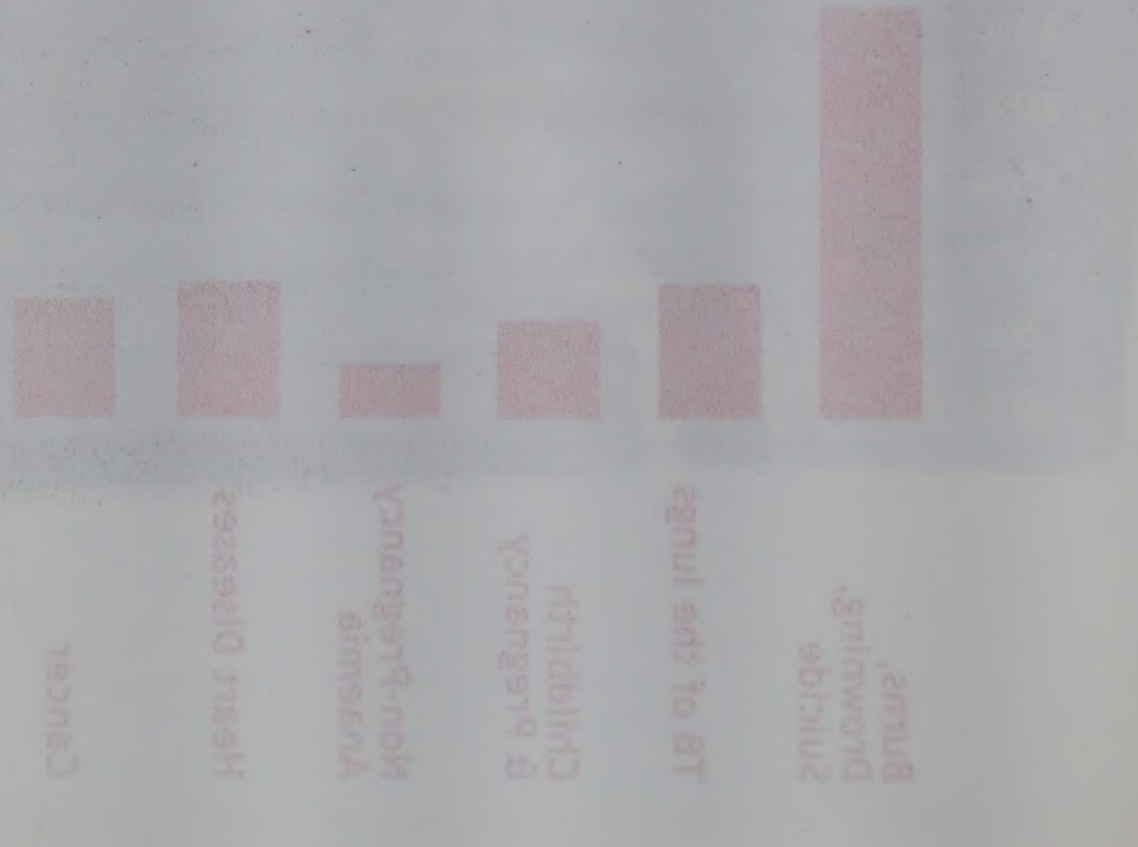
Causes of Death among women in Maharashtra (Rural) ages 15-44, 1996



Source: Compiled from Maharashtra Vital Statistics Handbook, 1996

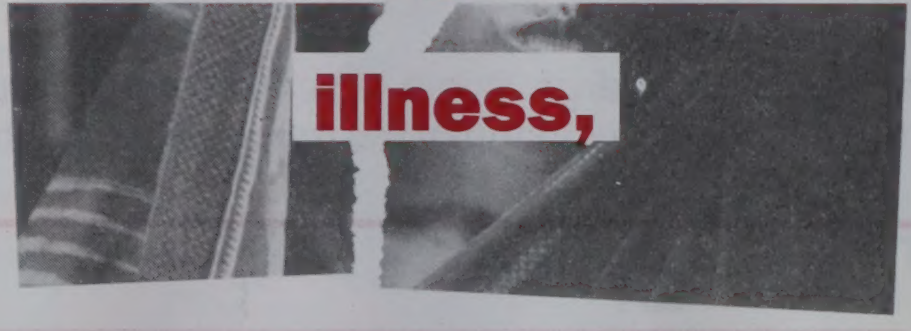
If the number of deaths due to violence is so high, then illness (morbidity) will be many times worse!

In that case, what is our responsibility towards prevention?



Violence on women is severe,

forms a large burden of



and has a serious impact

on the quality of life.

However violence does not receive
the same attention that TB or AIDS gets

We see that in the more 'developed' districts like Sangli,(850) Kolhapur,(897) Ahmednagar(890) etc., easily available technology such as sonography is used for sex determination to abort female foetuses.

We cannot prevent large scale discrimination against girls without the active participation of the medical establishment.

WE NEED TO EVALUATE THE PRESENT 'DEVELOPMENT STRATEGIES.

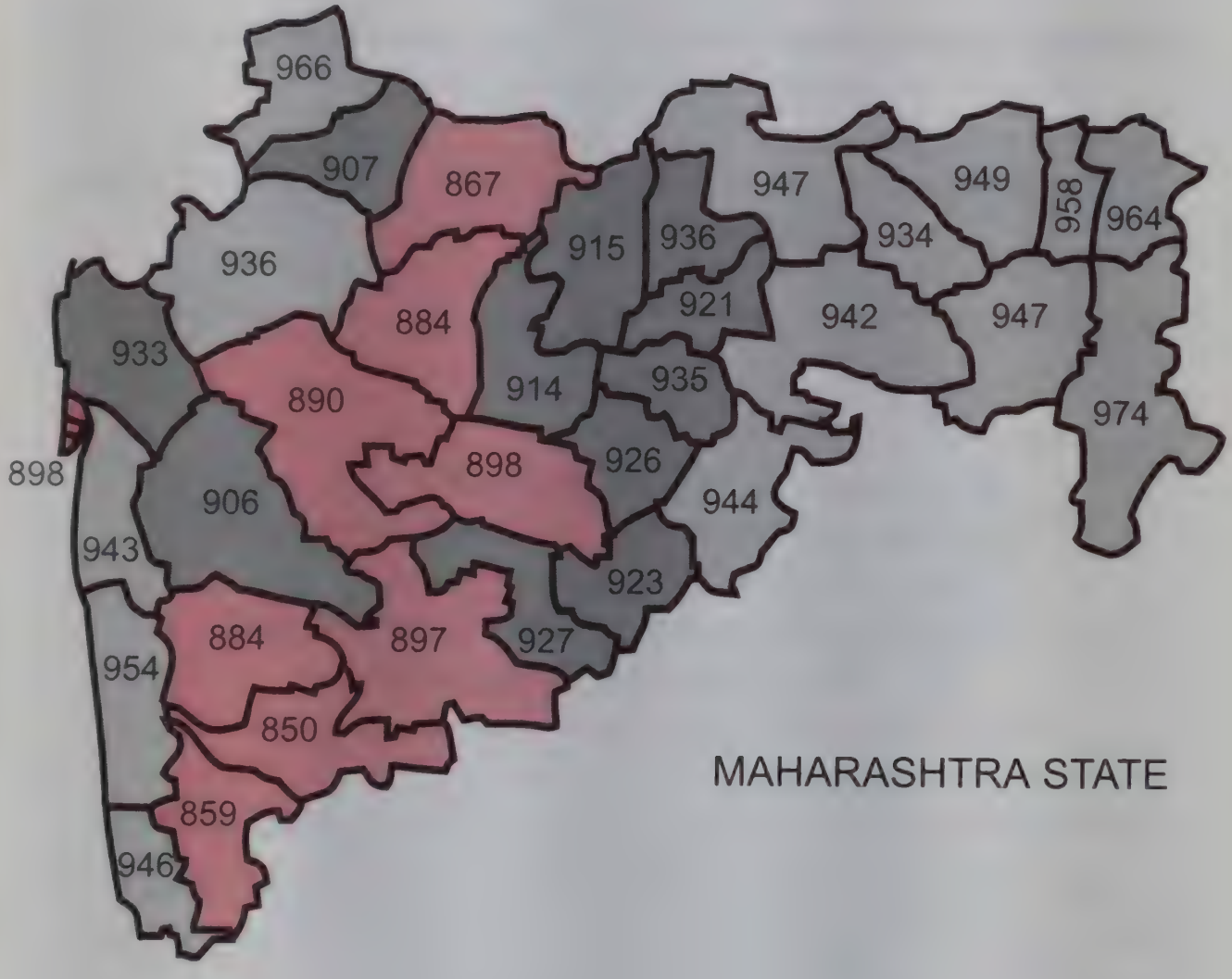
ANY PROGRESS OR DEVELOPMENT STRATEGIES NEED TO BE EVALUATED FOR THEIR SENSITIVITY TO WOMEN'S NEEDS.

Women face Violence right from before birth

Child sex ratio in Maharashtra
Boys : Girls (Ages 0 - 6)
(2001 Census preliminary results)

Number of girls per 1000 boys

Less than
975 940 900



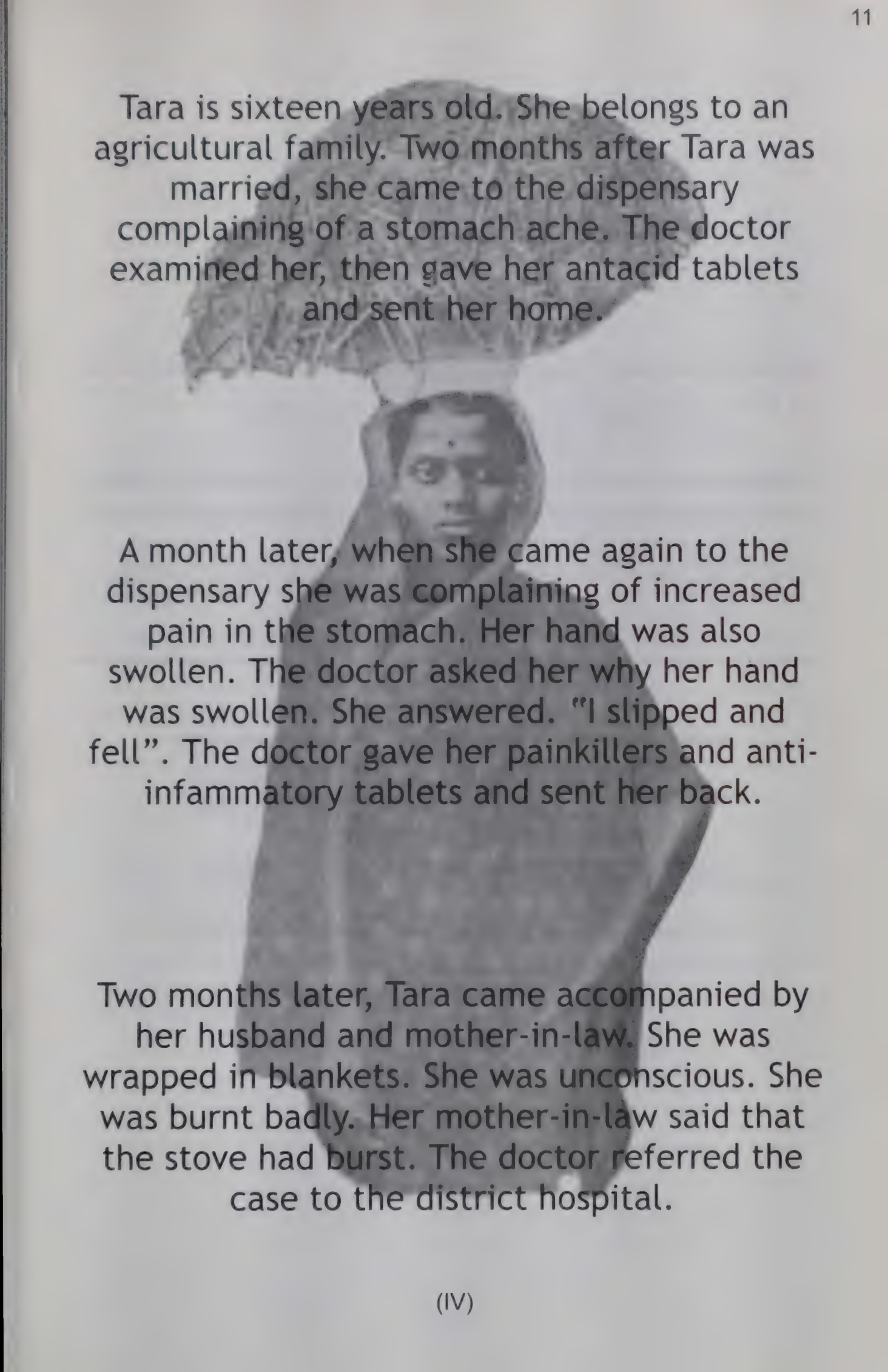
'Development' does not necessarily mean a better status for women

WHAT COULD HAVE BEEN DONE?

Perhaps asking more questions may have revealed the root cause for the stress/ illness.

The questions/ problems of newly married girls need to be addressed sensitively.

IF, FROM THE EARLY SYMPTOMS AND SIGNS WE ARE ABLE TO MAKE LINKS TO VIOLENCE, THEN PERHAPS WE CAN BRING DOWN THE NUMBER OF DEATHS DUE TO BURNS.



Tara is sixteen years old. She belongs to an agricultural family. Two months after Tara was married, she came to the dispensary complaining of a stomach ache. The doctor examined her, then gave her antacid tablets and sent her home.

A month later, when she came again to the dispensary she was complaining of increased pain in the stomach. Her hand was also swollen. The doctor asked her why her hand was swollen. She answered. "I slipped and fell". The doctor gave her painkillers and anti-infammatory tablets and sent her back.

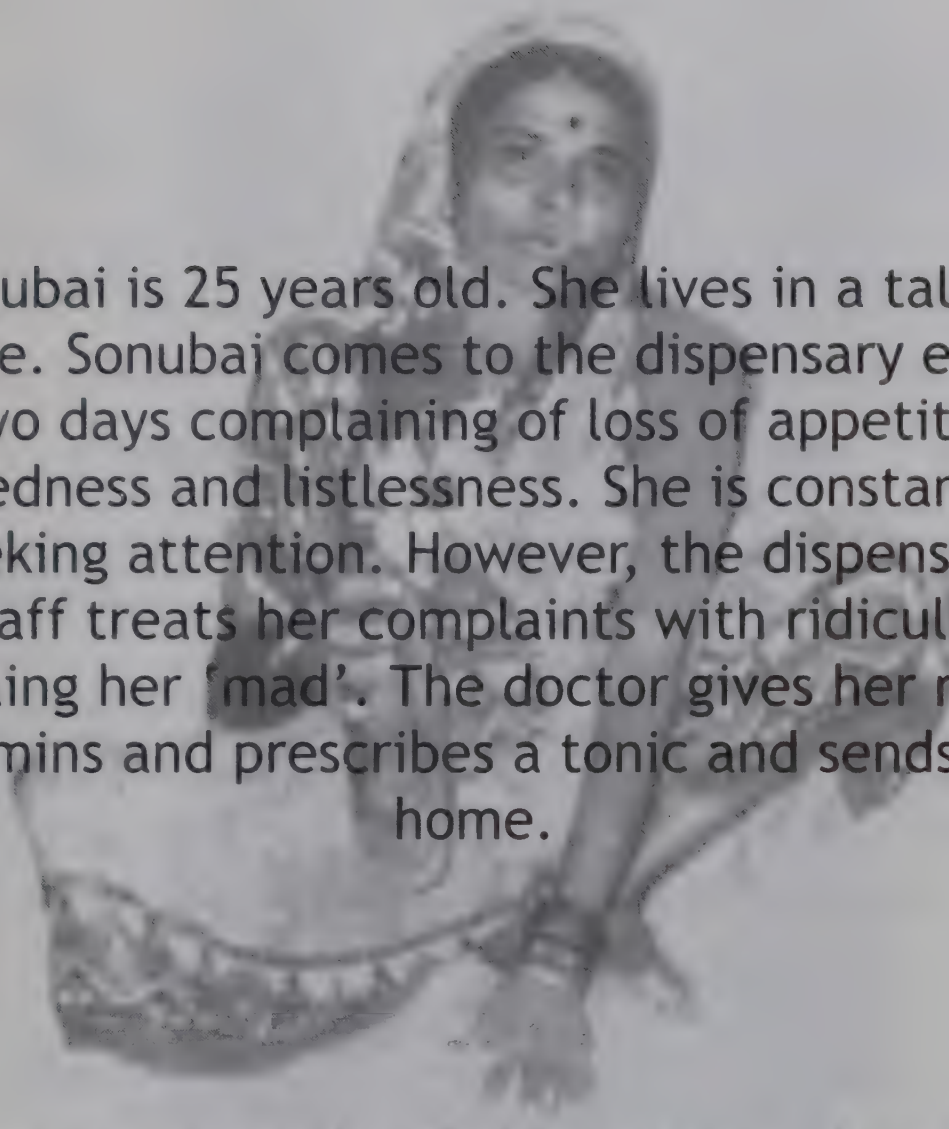
Two months later, Tara came accompanied by her husband and mother-in-law. She was wrapped in blankets. She was unconscious. She was burnt badly. Her mother-in-law said that the stove had burst. The doctor referred the case to the district hospital.

WHAT COULD HAVE BEEN DONE?

Incidence of violence in the past as well as a woman's status in her home are issues that must be taken into consideration.

How sensitive are we when we see symptoms of mental illness?

A WOMAN'S STATUS, PARTICULARLY IN HER HOME, AND VIOLENCE IN THE PAST HAVE FAR REACHING IMPLICATIONS FOR MENTAL HEALTH.



Sonubai is 25 years old. She lives in a taluka place. Sonubai comes to the dispensary every two days complaining of loss of appetite, tiredness and listlessness. She is constantly seeking attention. However, the dispensary staff treats her complaints with ridicule, labelling her 'mad'. The doctor gives her multi-vitamins and prescribes a tonic and sends her home.

After some months of this routine, she stops coming to the dispensary. Later there are reports that Sonubai has committed suicide by drowning. Her body has been sent to the district hospital for autopsy.

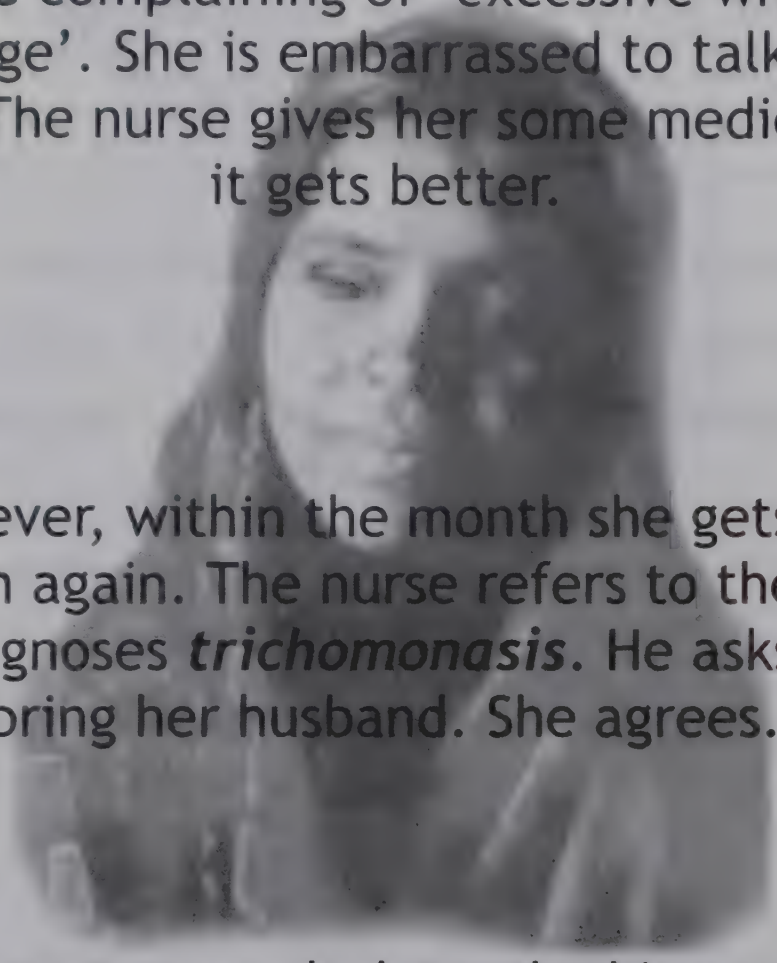
WHAT COULD HAVE BEEN DONE?

While advising treatment it is necessary to consider the social situation for compliance and to ensure that it does not lead to violence.

IT IS NECESSARY TO BE SENSITIVE AND MAINTAIN CONFIDENCE WHEN DISCLOSING STDs AND RTIs. IT COULD LEAD TO DISCRIMINATION AND VIOLENCE OF THAT FEMALE PATIENT.

IN SOME CASES IT COULD ALSO LEAD TO THE HUSBAND DOUBTING THE FIDELITY OF THE WOMAN CONCERNED.

Manda is a girl of 17 years. She comes to the PHC complaining of 'excessive white discharge'. She is embarrassed to talk to the doctor. The nurse gives her some medicine and it gets better.

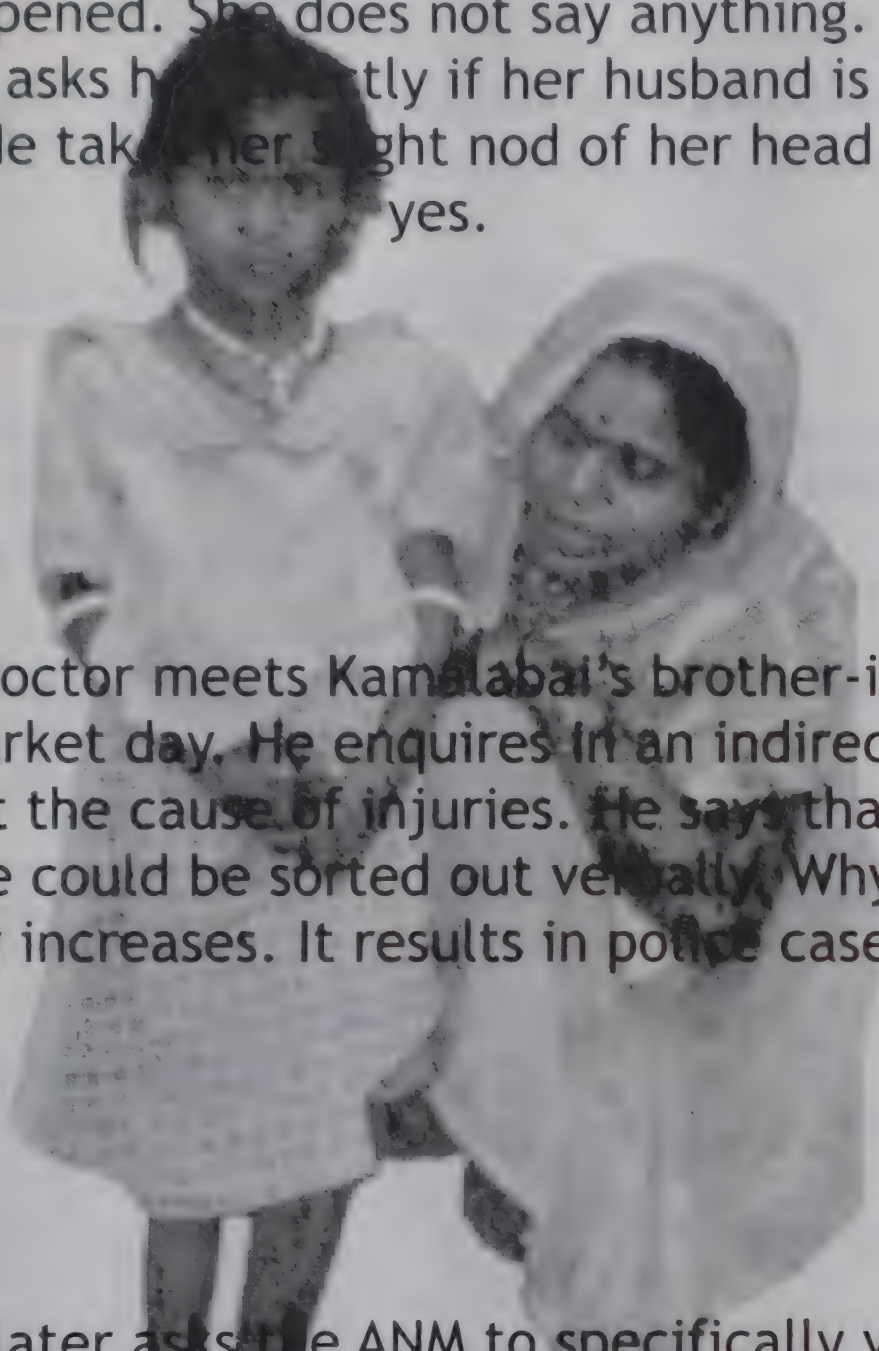


However, within the month she gets the infection again. The nurse refers to the doctor who diagnoses ***trichomonasis***. He asks her to bring her husband. She agrees.

She returns two weeks later, looking very weak and anaemic. She explains her husband cannot come, as he has to go repeatedly out of the village for work. He cannot find the time. The nurse discovers bruises on the neck, but says nothing.

SOMETIMES WITH SMALL GESTURES AND A LITTLE PRESSURE ON FAMILY MEMBERS, A DOCTOR CAN TAKE POSITIVE STEPS TO STOP VIOLENCE.

Kamalabai visits the PHC with injuries on her face and hands. The doctor enquires what has happened. She does not say anything. The doctor asks h tly if her husband is hitting her. He tak her ght nod of her head to be yes.



The doctor meets Kamalabai's brother-in-law on market day. He enquires in an indirect way about the cause of injuries. He says that any dispute could be sorted out verbally. Why beat? It only increases. It results in police cases etc.

He later asks the ANM to specifically visit Kamalabai's house and speak to her. Later on, the ANM reports that the violence has stopped. Kamalabai bringing her child to the PHC also reports that she is not being beaten.

* Women in situations of violence are unable to make decisions regarding contraception, even if available.

* They are more susceptible to STDs and RTIs.

* Violence affects the emotional health of their families.

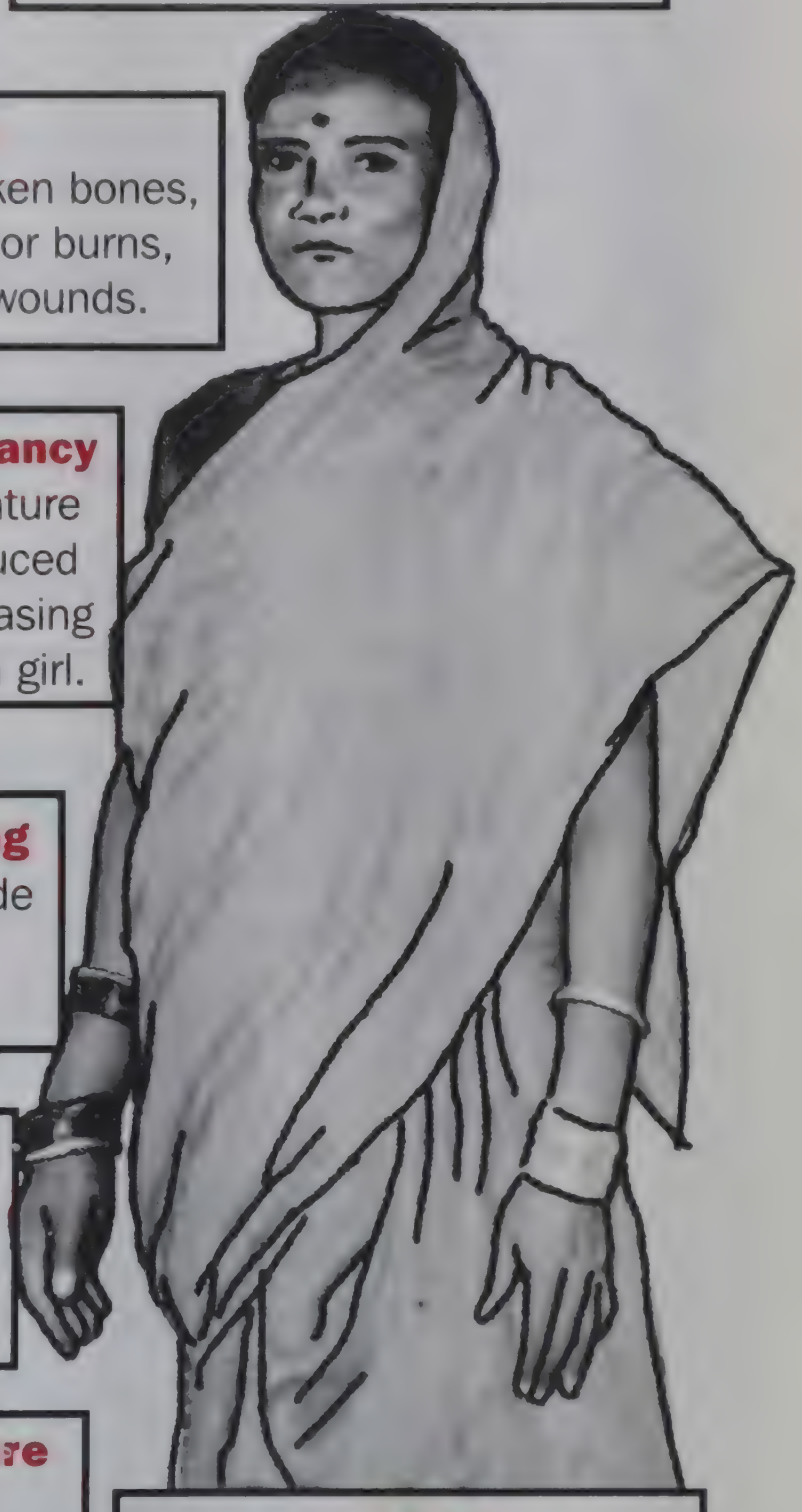
OFTEN THE PHYSICAL WOUNDS MAY HEAL, BUT THE MENTAL WOUNDS CAUSED BY VIOLENCE OFTEN LAST A LIFETIME.

What are the Health Consequences of Violence?

Psychological Problems and Suicide
– disturbs the emotional life of families, could result in suicide

Injuries
– bruises, cuts, broken bones, broken heads, minor burns, acid burns, stab wounds.

Battering during pregnancy
– injury to mother, premature births, miscarriages, reduced chances of survival, increasing battering if child born is a girl.



Barrier to Family Planning
– unlikely to be able to decide about contraceptives, repeated abortions.

Reproductive Health
– is particularly vulnerable to violence, increased threat to STD & AIDS

Access to Health Care
– unlikely to come forward to take treatment or delays in reaching the health services

Homicide
– dowry deaths, 'stove bursts', accidental deaths

All gender discrimination is a form of violence, as seen in

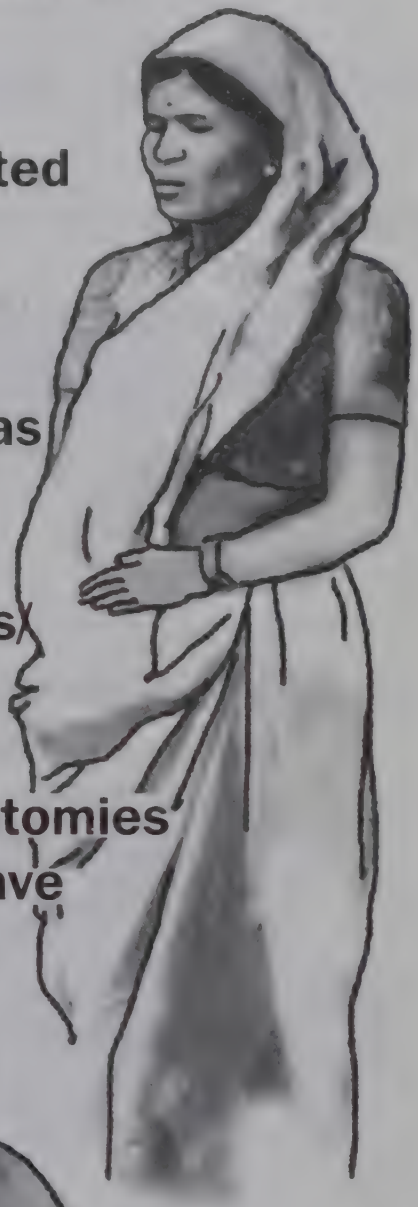
- repeated abortions of the female foetus
- less food to female children and women in the household
- delayed and lower access to health services

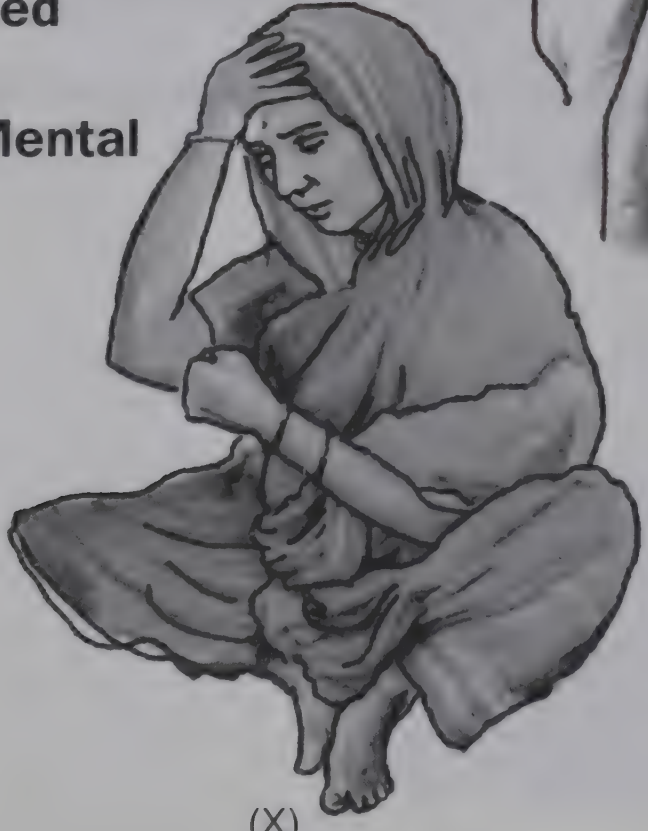
GENDER BASED VIOLENCE IS KNOWN TO INCREASE DURING TIMES OF WAR, RIOTS, UNEMPLOYMENT AND ECONOMIC RECESSION.

When are Women most Vulnerable to Violence?

All women are vulnerable to violence. However, risk of violence is known to increase ...

- During Pregnancy
  – with abdomen being targeted
- With STD and HIV infections
- In long term illnesses such as Tuberculosis
- With Infertility/ childlessness/ bearing only girls
- After Tubectomies/ Hysterectomies when reproductive values have diminished
- During Mental Illness





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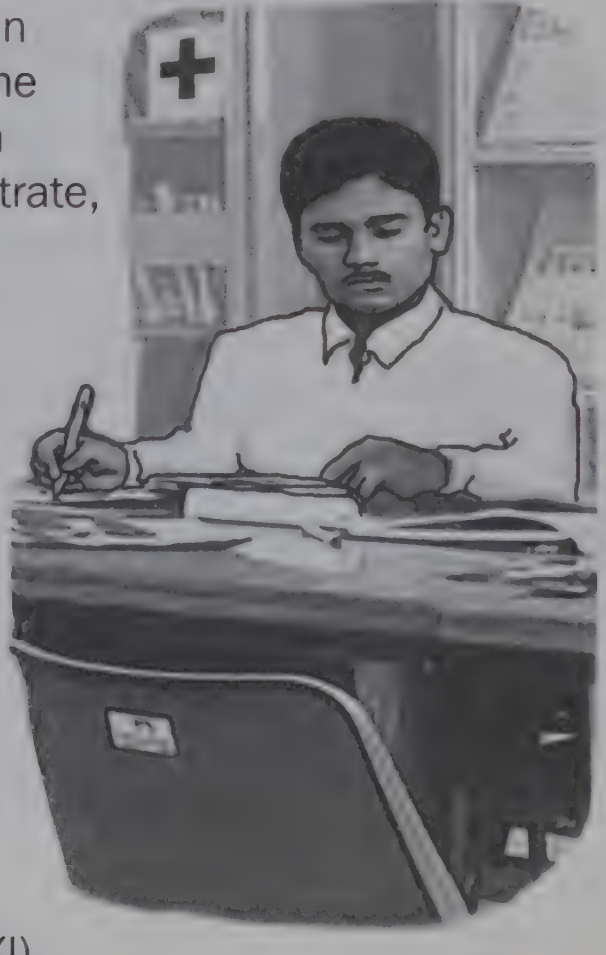
Health education to doctors and other personnel such as ANMS should include issues of violence on women.

DOCTORS AND HEALTH PERSONNEL ARE AT THE FOREFRONT TO DETECT CASES OF VIOLENCE.

Role of Medical Officer

Where health workers and Medical Personnel suspect cases of domestic violence, they could.....

- **make a note on the case paper** of 'possible case of violence/ suspected cause is violence'
- **ask discreet questions,**
- **listen to the woman's story** and **put her in touch with support agencies** such as Mahila Mandals, women's organisations, local NGOs, woman representatives of the gram panchayat.
- In government hospitals it is mandatory for doctors to **inform the police** in case of all accidents, suicides and homicides.
- All MBBS doctors in government service are **gazetted officers.** In cases of serious violence, he/ she could use their power to write in confidence to the District Magistrate, Public Prosecutor or District Collector.



* Care should be taken of women's safety and that violence on them does not increase.

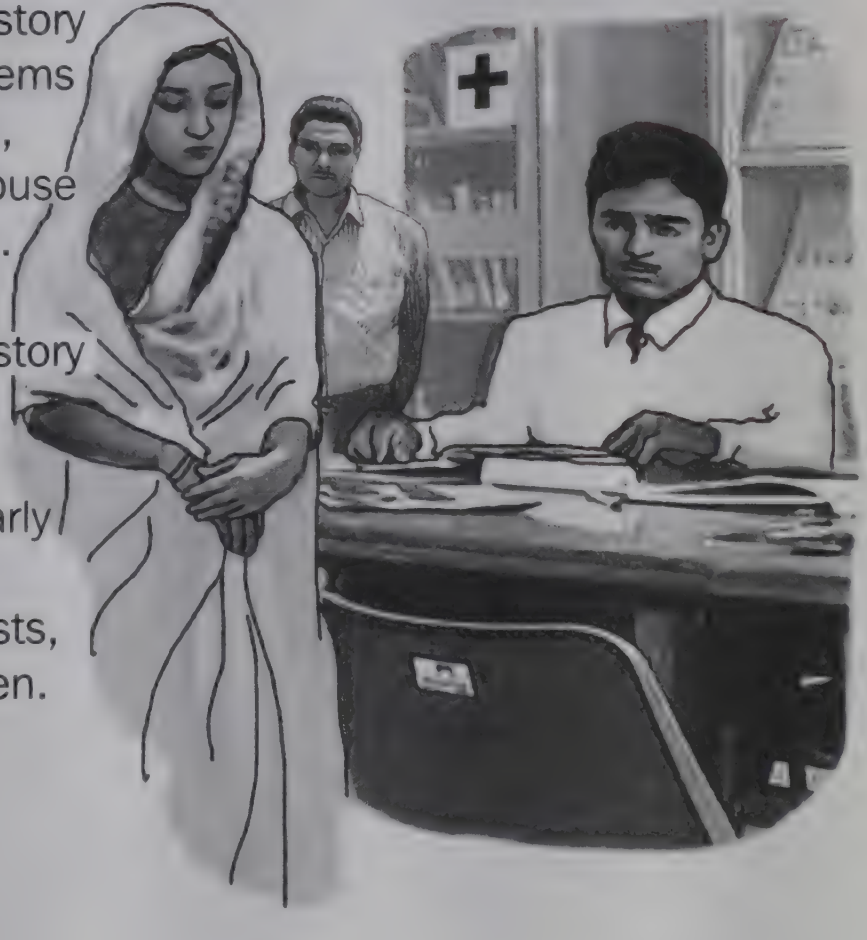
* While writing the case paper, the focus must be to ensure that the woman gets maximum justice.

JUST AS IN DIAGNOSIS OF CANCER, A 'HIGH DEGREE OF SUSPICION' IS REQUIRED, SO ALSO CARE SHOULD BE TAKEN WHILE MONITORING ILLNESS CAUSED BY VIOLENCE.

How can Health Workers recognise cases of Violence?

Signs of violence are –

- a woman who comes with multiple injuries in sites that are usually covered by clothing,
- a woman whose partner comes with her and stays close at hand in order to monitor what is said.
- with evidence of strangulation attempts on the neck, or fractures to the upper arms (which may be caused when the woman tried to defend herself),
- an excessively shy woman, embarrassed or anxious or who is reluctant to provide information about how she was injured.
- a woman with a history of psychiatric problems such as depression, alcoholism, drug abuse or suicide attempts.
- a woman with a history of 'accidents'.
- a woman, particularly if pregnant, with injuries to the breasts, genitalia or abdomen.



Tackling of violence is at 3 levels (just as in the case of Malaria or TB)

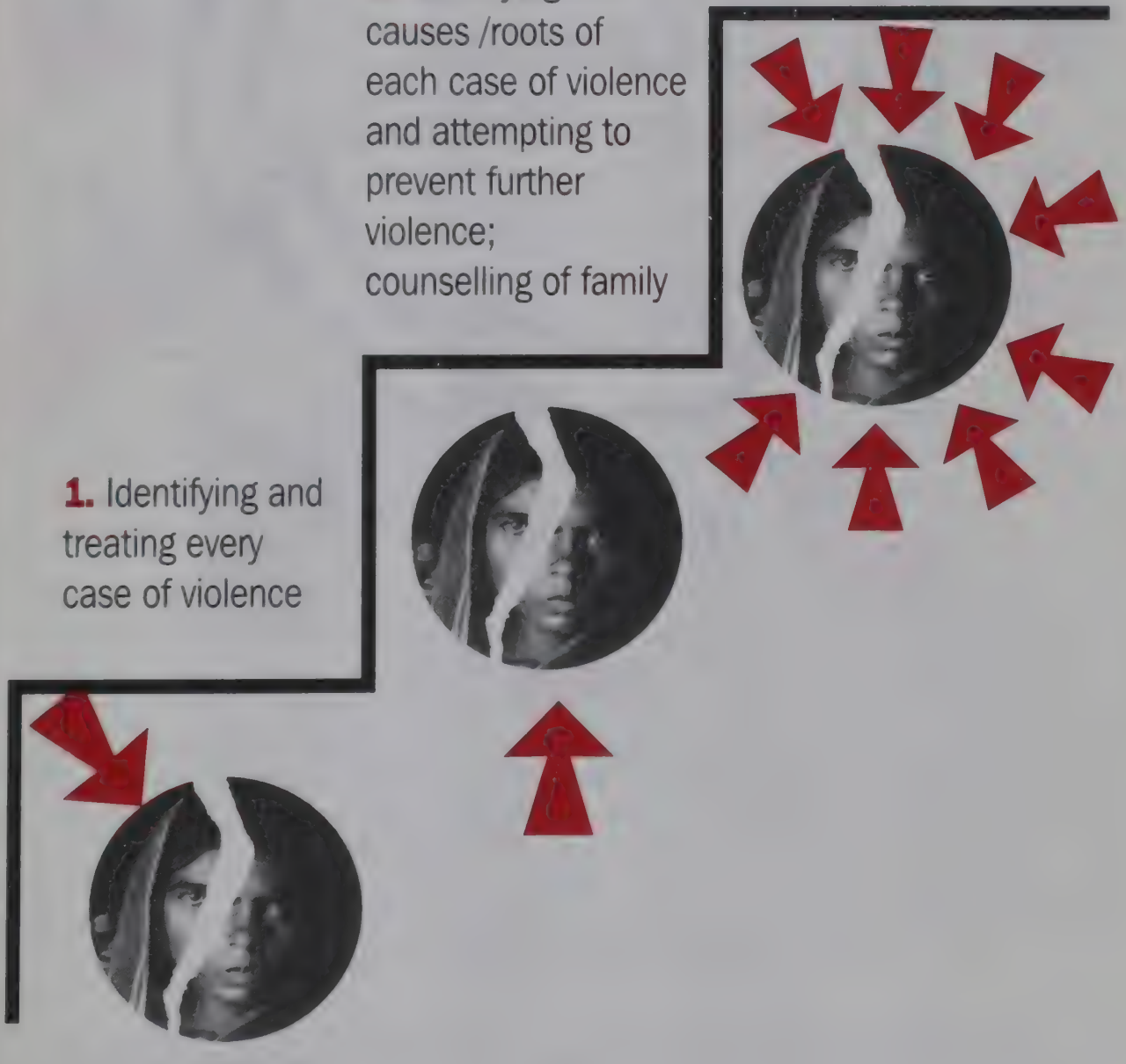
* At the level of the patient - diagnosis and treatment
* Source of illness - family, dealing with the cause of violence through intervention, counselling etc.
* Prevention at policy level and through interlinkages with other agencies such as law, judiciary, social and political groups.

What can be done to reduce cases of violence against women?

3. Taking preventive steps at the socio-political level and so ensuring a society without violence on women

2. Identifying the causes /roots of each case of violence and attempting to prevent further violence; counselling of family

1. Identifying and treating every case of violence



Health services
Political leaders
Social Workers
Law
Families
Judiciary
Government
Women
Police
Men
Gram Panchayat
Doctors Nurses
Let us all work together to prevent gender violence

I VIOLENCE ON WOMEN IS ENDEMIC!!

Violence on women is a common everyday occurrence. Of this, domestic violence particularly, has become a culturally accepted phenomenon. It has no boundaries of religion, region, caste or class. It is a 'common', 'daily', 'widespread' affair. It is also a 'shocking', 'unjustifiable', 'most endemic' form of violence that results in untold physical and psychological harm and suffering to women.

In turn, women have culturally accepted violence as normal and a woman's fate. Sexual abuse, gynaecological problems, menstrual difficulties, contraceptive side-effects, miscarriages, stillbirths and potentially life threatening clandestine abortions or childbirth are considered normal and women bear them silently.

The latest NHFS-2 figures report that almost 1 in 5 ever married women have experienced domestic violence. Similarly, 1 in 9 women reported being beaten in the last 12 months. Given the tendency to under-report wife-beating this could only be the tip of the iceberg.

This reflects the low social status of women in our country, and is perhaps most visible in the falling child sex ratios. Traditional preferences for a male child, along with easily available modern technologies (like sonography) has resulted in large scale abortions of female foetuses.

In addition, we have a National Population Policy which links various government benefits in health, education, jobs and public office to the two child norm. The preliminary results of the Census 2001 reveals that sex ratios have particularly fallen in economically leading states like Maharashtra from 934 in 1991 to 922 in 2001, to below the National average. This belies the notion that economic progress will automatically lead to better social status.

In the same way, violence against women is systemised in the way women are victims in all conflicts. We witness this in the post Babri-Masjid demolitions, in the bomb-blast riots in Mumbai, in all caste and land conflicts, rape and molestation is used as a tool to control the protest.

Social Status and Violence: While understanding the issue of violence we need to consider that women belong to different income groups, caste, region, religions, and speak different languages etc. Therefore, the specific nature of violence faced and the ability to protest or move out of violent situations also differs. Among the few studies done on the extent of violence in India, one study reveals that a larger number of women in Uttar Pradesh fear their husbands, or suffer violence, than in Tamil Nadu. This could be linked to the fact that women in Tamil Nadu are more educated, more likely to work for wages and have greater decision-making authority in terms of both household purchases and child-rearing. They also have a greater freedom of movement and control over economic resources than north Indian women have.

This indicates that violence is linked to the social milieu in which women live. Significantly it is found that it is the region (where a woman may live) and not religion that makes a difference to the extent of violence she may encounter.

Education: Similarly, education also plays a role in combating violence. It strengthens the woman's capacity to assert herself. It was found that women who had studied up to the primary and secondary levels in Tamil Nadu had a better edge in combating violence within the home. In the more patriarchal Uttar Pradesh it needed women to have studied up to the seventh standard to reach this level of protection.

Even so, we see that education as it is today does not seek to break through gender stereotypes. Medical Education, in particular, has been strong in reinforcing sex roles. Doctors act as moral policemen defining - what it is to be a woman, and to be a mother in particular. They may attempt to exercise control by refusing an abortion, or ideological control as in the case of psychiatry.

The education system may also glorify violence in the way 'wars' and 'great conquests' are taught to children.

Marital Age: The same study also showed that women who are married at ages of 18 and above are less vulnerable to abuse and intimidation than those who are married at very young ages. Children married at the ages as low as 13, are particularly unable to fight violence, and live in constant fear in their marital homes.

II FORMS OF GENDER-BASED VIOLENCE

Gender-based violence includes any kind of verbal or physical force, coercion, or life-threatening deprivation, directed at an individual woman or girl. This violence may cause physical or psychological harm, humiliation or deprivation. It is the sanction of commonplace violence on women that perpetuates female subordination.

Violence could take the form of physical violence such as beating, slapping, kicking, assault, acid throwing, murder etc. Sexual violence comprises all kinds of sexual assault and abuse, molestation, rape etc. The third kind of violence faced by women is psychological violence. All kinds of ill treatment, mental torture, negligence, deprivation, emotional ransom, verbal abuse, intimidation, eve teasing, restrictions of moving out of the house, dowry harassment have psychological impact on a woman's life.

All non-accidental injuries are termed as violence. Of these, wife-beating and intimidation are the most endemic forms of violence. However, we see that very often violence related injuries such as burns as termed as accidental 'stove bursts'. Or, 'drowning' is often reported as accidental but could very well be provoked.

III VIOLENCE AS A PUBLIC HEALTH ISSUE

Gender based violence forms a large burden of illness. This is indicative from the large number of women dying of violence-provoked causes. This in turn puts a large load on the existing health system. However, though road accidents are

recognised as a cause of morbidity and mortality among men, burns and violence provoked illness among women is not mentioned. By recognising it as a health problem we can then begin to address why it happens. And then the measures to tackle it can be undertaken.

The inclusion of violence as a health issue highlights the widespread nature of gender based violence. It is no more only a law and order problem. Nor is it the 'problem' of single households but the cause of illness, ill health and death in proportions higher than TB of the Lungs, Pregnancy related causes, Anaemia and Cancer put together.

The Medical Profession and Health workers have a particular service within this social milieu. Take the case of sex-selective abortions.

Firstly, any couple seeking sex-determination of their to be born child approaches the medical establishment to conduct the procedure. Without the active participation of medical practitioners (mostly private doctors) sonography and amniocentesis tests cannot be done. In the sonography test the sex of the child cannot be correctly known till after the fourth month of pregnancy. Such abortions could seriously affect the health of the woman as well.

Secondly, in the case of any woman facing physical violence she may be reluctant to disclose it. She may however, at some time seek medical attention. Particularly, if the injury prevents her from continuing her daily chores, she may visit the doctor or the PHC. **Thus, the doctor and health workers are at the very forefront of combating violence and particularly domestic violence**. The roles of health professionals' range from noting down the possible co-relations between injuries and illnesses, to violence. This would also help in being able to map the extent and kinds of violence faced by women. Right through a woman's life cycle she faces violence. Most assaults on women occur in the home. Women remain silent and do not report it. Often when they do reach a doctor - the family allows it as the doctor is considered neutral - victims do not speak out and hide the actual reasons of their injuries.

III HEALTH CONSEQUENCES OF VIOLENCE (also see flip chart VIII)

Injuries such as bruises, cuts, broken bones, head injuries, minor burns, acid burns etc could all be the result of violence. Chronic injuries and disabilities such as hearing loss, head-aches are also common. Violence could result in homicide as well. Women are more likely to be murdered by a husband or intimate partners. Dowry deaths are common in our society. In Urban Maharastra 1 in 5 married women in reproductive ages die due to 'accidental burns'.

It is known that battering increases during and after pregnancy. Most often it is the abdomen that is targeted. Battering during pregnancy may cause injury to the mother, premature labour, miscarriage and birth of premature or low-birth weight babies with reduced chances of survival.

Battering could also increase if the child born is a girl - despite the scientific fact that the male sperm determines the sex of a child. Again, very often the woman

is reluctant to have to go in for such abortions, but is pressurised into it by her family, growing social, economic pressures and existing population policies.
Violence also results in women being unable to make decisions about contraceptives, even when available. Sometimes, a woman may use contraception on the quiet, but would face increased violence if the husband found out. Violence can also increase when a woman talks about contraception, or insists the man wear a condom. He wants to know why. She is particularly vulnerable to repeated STIs and HIV infections.

Violence disturbs the emotional life of families. Physical injuries may heal. But psychological damage lasts forever. A woman's life could be the constant feeling of - first he insults me, he beats me and I have to put up with it because I have nowhere to go and sometimes I feel like I don't want to put up with it anymore. It is known that more married women are likely to be depressed.

Understanding Gender Violence (also see flip chart VII)

Violence on women is found everywhere. Women are battered and raped in the US, Russia, Britain as well. Violence takes place in all kinds of families. In higher income families, the violence is only more silent but present as well. The World Health Organisation believes that at least one in five women have been physically or sexually abused by a man at some time in her life.

Though violence on women has gone on for centuries, it has not yet been addressed. It is so close, in the home, school, neighbourhood, etc. that everyone experiences it, yet it has not been addressed as a problem the way AIDS or TB may find continuous mention. Instead, violence on women is under recorded and remains disguised. All of us would have had an experience where violence has provoked a burns death but instead it has been recorded as 'accidental' stove burst.

It occurs to women at all stages of the life cycle. It could start from the foetal stage. The high male preference particularly in countries like ours, leads to sex determination, selective abortions and female infanticide.

Women's rights are human rights. Any violence on women based as a result of her gender becomes a violation of her human rights.

A woman's reproductive health is particularly vulnerable to violence. Her ability to decide - if, when, and how to bear and raise children is particularly affected. This affects her sexual and reproductive life in direct and indirect ways

IV CHALLENGES FOR HEALTH PROFESSIONALS AND HEALTH WORKERS (also see flip charts IX & X)

Dealing with violence as a cause of illness falls into the role of the Medical Profession just as in the case of any other illness. Often it is uncomfortable, difficult and time-consuming to discuss, abuse in the home. However, all health workers, PHC staff and MOs have an important role to combat violence and

help abused women. Health Professionals and Health workers need to accept the challenge and deal with violence with the same suspicion they use to detect cancers. Just as the detection of cancer requires 'a high degree of suspicion'; the same is the case in violence related morbidity. They need to be aware that their role in combating violence is pivotal.

Taking a note of violence related cases, would give us an idea of the extent of violence and could also be used as evidence if the woman seeks justice. It is necessary to be sensitive to the woman, ask discreet questions and listen to her, put her in contact with Mahila Mandals, Women's Organisations who may help. Informing the police in all cases of all accidents, suicides and homicides will help.
Liasoning with agencies within the village/ city helps in bringing 'violence' out into the open.

While dealing with violence related cases health professionals must take the utmost care to see that the women and her family receives utmost justice. Therefore, the stress must be to ensure the maximum penalty to the abusers.

Therefore how can a doctor intervene?:
The three levels at which a doctor can intervene could be at the level of (**see flip chart XIII**) -

- the body: treating the woman ensuring she gets relief. Ensuring that all the protocol necessary such as noting the case of violence down, etc. as mentioned earlier is done.
- immediate environment: counselling the family members, husband and preventing a repetition of any incident of violence. Steps can also be made to note of all aspects of the case that ensures an individual woman gets justice. By making interlinkages with the law enforcing agents like police, magistrates etc to ensure that conditions in society where violence does not breed.
- by changes in the society: by campaigning at the policy level, and creating awareness, bringing in long term changes in the socio-political arena to ensure violence on women decreases.

Similarly, while approaching a doctor in case of an incidence of violence, it is important to insist that the doctor and the social worker take note of -

- Gravity of the assault
- Will or desire of the woman
- History of past assault
- Events leading to the present assault
- Assault reliability
- History (past record) of husband (abuser)

This would serve as an important record in case the woman ever seeks legal justice.

Turning a blind eye towards violence puts Health Professionals and Doctors in the role of 'abetting' with the abuser and perpetuating violence. It is important that Health Professionals work along with the Police, the Legal Systems, Social Workers and families both to sensitise them as well as bring justice to women. After all, these women are our mothers, sisters, daughters and daughter-in-laws. They are the women around us. And unless we raise the consciousness against violence, we are not immune to violence happening in our own families.

V MAHARASHTRA

Violence in Maharashtra

Overview: According to the latest published police records, the crimes against women registered with the police have actually fallen! See the table below.

Crime against Women 1997-1999

Crime Head	1997	1998	1999
Rape	1246	1154	1320
Kidnapping & Abduction	820	772	727
Dowry Deaths	420	420	395
Torture	8111	7728	7026
Molestation	3131	2923	2766
Sexual Harassment	835	765	825
Importation of Girls	0	0	0
Sati Prevention Act	0	0	0
Immoral Traffic (P) Act.	1653	444	390
Indecent Rep. of Women (P) Act.	30	36	147
Dowry Proh. Act	24	24	14
Total	16270	14266	13610

Source: Crime in Maharastra 1999, published by State Crime Records Bureau State CID M.S.. Pune. pg 156

However, these figures must be viewed with caution. Cases registered with the police are reflective of the number of women who pick up the courage to reveal violence in the hope of justice.

Maharashtra features second after Uttar Pradesh for crimes against women in 1995 (15378 cases), while Mumbai registered the largest number of cases of violence against women among selection of metropolitan cities in the country.

Similarly, a study of scrutiny of casualty department records, of JJ Hospital in Mumbai, for 1996 revealed that 22.4% of cases were directly cases of domestic violence where the woman mentioned their husbands, or another family member had assaulted them.
Another 44% of cases were that of 'possible domestic violence'. These are cases of women committing suicide, those who had suffered accidental burns, and those suffering assault but refusing to name the person who had committed the act of violence.

Violence among youth: Maharashtra has seen a rise of violence against teenage girls. In the four years (1996-99), at least 65 girls lost their lives. More than half of these girls were below 18 years and 2/3 of the accused were below 25 years of age. Of these are many instances of the girl saying 'no' to a boy's proposal of friendship/ marriage. Besides, young girls being killed they were harassed and attacked, sometimes by stabbing, burning alive or throwing acid. Many of the boys attempted suicide after the incident.

VI MORTALITY AND WOMEN IN MAHARASTRA

Up to the age of 34 the death rate for women is higher than men in Maharashtra. This is in spite of an adverse sex ratio at birth. The major reason for death in the 0 -1 age group is 'prematurity'. This is significantly higher than the all-India averages. It is known that teenage mothers, as well as anaemic mothers are more likely to have low-weight, premature babies.

While reviewing the major causes of death for men and women in Maharastra, Burns emerges as the single largest cause of death for women in the reproductive age group of 15-44 years (15.05% of all deaths; see Flip chart I). For men in the same age group it is vehicular accidents (15.10%) that claim an almost equal number of lives. The important difference here is that for women the **most unsafe place is her home**. Almost all the burns 'accidents' take place within the home.

Another 4.5% of women die of drowning, 6.41% by Suicide, 0.47% by Homicide in this age-group. All these causes of death have a strong co-relation to gender based violence. Together, they claim 26.5% of all deaths in this age group.
This suggests very strongly the low social status of women even in a 'progressive' and 'developed' state like Maharashtra .

The sex ratio

The sex ratio for Maharashtra has dropped from 934 in 1991 to 922 in the year 2001. This is below the national average of 934.

Sex-ratio in India and Maharastra 1901 -2001

	All-India	Maharastra
1901	972	978
1911	964	966
1921	955	950
1931	950	947
1941	945	949
1951	946	941
1961	941	936
1971	930	930
1981	934	937
1991	927	934
2001	933	922

From the above table we can see how the sex-ratio in India and Maharastra has been declining over the last century. This alarming trend is more obvious when we look at the number girls in the age group of 0-6.

The Child Sex Ratio (CSR): The child sex ratio for districts in Maharashtra shows that the more developed districts do not necessarily mean a better status for women. It could in fact mean a lower social status, and increased violence. This is seen in the shockingly low sex ratio in the child population aged 0-6 particularly in the sugar belt of Western Maharashtra. (see map on flipchart III) If the sex ratio at birth were taken into account it would probably be even lower.

VII MORBIDITY AND WOMEN IN MAHARASHTRA

While reviewing the data available for mortality we must be aware that what results in mortality is only the tip of the iceberg. Morbidity is what women live with everyday. Being unwell would automatically reduce the ability to challenge or remove oneself from violent situations. It also works as a viscious circle. Being continuously unwell reduces a woman's ability to work. And, thus she is more prone to violence. Her low self-esteem she often disregards her own ill-health and this keep her from timely treatment particularly for reproductive tract infections.

Anaemia

Many of the same reasons that account for starvation deaths are responsible for high proportions of anaemia in women. In vulnerable populations (such as slum populations, tribal and poor households) in Maharashtra, anaemia is present in almost 90% of women. The proportion of severe mal-nourishment among rural girls is two to three times that of boys, though the actual extent of malnourishment has fallen over the years. The recent NHFS-2 findings show that among women aged 15-49, 48.5% have anaemia. Severe anaemia (ie. below 7 Hb) is present in 3.8% of all rural women and 1.5% of all urban women.

Gynaecological Morbidity

Gynecological morbidity includes Reproductive Tract Infections of women and Sexually Transmitted Diseases including HIV/ AIDS. Very few community-based studies have been done in Maharashtra to determine the extent of reproductive tract infections (disorders of the genital tract not related to pregnancy etc). Below are the findings of two studies. One study was conducted in rural Maharashtra, and one in the slums of Mumbai.

	Rural Maharashtra	Mumbai Slums
Women reporting one or more gynecological problem	55%	74%
Vaginitis	62%	15%
Cervicitis	48%	40%
Cervical erosion	46%	21%
PID	24%	16%
Diagnosed Prolapse	1%	18%

In both the studies it is noted that though a high percentage suffer gynecological diseases only a few had ever sought medical care. It has also been seen that gynecological complaints were higher among women who have undergone sterilisation operations or who are using IUDs. Many women attributed their complaints to the tubectomy operations.

VIII IN CONCLUSION

When we looked at reasons of death among men and women in Maharashtra from a health angle, we found that the single largest cause of death for the women (15-44 age group) is burns. This fact reaffirms that health is closely linked to social status and not just about viruses or micro-organisms or infectious diseases.

Here we understand violence to be the use of force by persons in positions of power. These positions of power may be assumed and sanctioned in society. To keep these positions of power it then becomes necessary to use violence.

Looking deeper we find that violence against women is also a reflection of the social and economic processes taking place around us. This has its own impact on the personal sphere and on man-woman relationships as well.

In the present consumer economy the need for cash is utmost. One way of meeting such needs is through demands for dowry. To meet such demands the perception of the woman as a burden is essential. To maintain this perception violence is then a tool.

Another aspect of dowry demands is the increased demand for 'cash'. With the shrinking job market, cash serves as 'capital' to start a small business, or as income generation. Again, increased wife-beating and abuse is also related to the tensions and frustrations faced by male workers who are losing their jobs and means of livelihood.

The fast and sudden deterioration of living standards, the sudden loss of traditional roles (where the man of the house cannot find the means to be the traditional 'breadwinner') creates confusions and a general insecurity in society. Increased alcoholism could be a reflection of such insecurity. Women seeking employment outside the home are viewed with 'suspicion' and beaten for disloyalty.

The different components of the society, such as the media work together to ensure women's low status in society. The recent focus on beauty queens, models and glamour in the print media as well as in movies creates both a sense of aspiration and confusion in young minds. A reflection of the aspirations can be seen in the large number of girls falling prey to promises of jobs as models and in movies and then held ransom. We have seen this in the sex scandals of Jalgaon (1993), Nasik (Malegaon) and Satara (2000). The confusions can also be seen in the rise of 'one-sided love' incidents in Maharashtra.

The law and the judiciary play their own role, in which the individual perpetrators of such crimes are not penalized. It is common experience related by many women that they face reluctance and biases when they go to police stations to register a case of harassment.

All these work to create the understanding that (ironically) the woman's place is her home. And, it is in that home that she is most unsafe.

All the enabling factors such as education, employment, housing and good and available health services, are virtually absent.

However, it must be understood that in calling for doctors to be more responsive to victims of violence, or in citizens demanding that measures be taken to prevent violence on women, that the fundamental questions of inequality between men and women will not be altered. That doctors be responsive to victims of violence is a necessary but not sufficient condition for preventing violence. This would need a much larger transformation of social and economic life.

The struggles for recognition within the medical establishment forms only one aspect of a struggle for a healthier society. This is important as it reveals one aspect of social and economic life that makes us unhealthy.

This makes us aware of the fundamental contradictions in which we live. Our understanding of the impact of living and working conditions, and social and economic relationships also need transformation if we are to achieve a society where women are free from gender based violence.

Thus, the answer does lie in the broader movement for transformation of society itself.

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SOME FACTS ABOUT MAHARASHTRA

The average age of marriage in Maharastra is 15.8 years (1991 census).

In Maharastra, Medical Officers (at Rajgurunagar PHC, Pune district) expressed concern about the trend where women have undergone sterilization operations by the age of 16-17, and hysterectomies by the age of 22-24.

The sex ratio for Maharastra has fallen to 922 females per 1000 males (2001 census, preliminary results).

The child sex ratio for Maharastra is even lower at 917/1000 males (2001 census, preliminary results).

ABOUT THE JAN AROGYA ABHIYAN

Governments & international agencies have forgotten the goal of HEALTH FOR ALL BY 2000 A.D. But we, the people cannot forget it. It is time to strengthen and expand people centred initiatives - to find innovative solutions and to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining HEALTH FOR ALL means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the 'Health For All' call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called Jan Arogya Abhiyan. This has three broad objectives:

- To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- To reinforce the principle of health as a broad inter-sectoral issue.

tathapi
'Women and Health' Resource Development

425 DP, 77 Mukund Nagar
Tilak Maharashtra Vidyapith Colony
Pune 411037 Maharashtra, India
Telephone: 91-20-4270659
Email: tathapi@vsnl.com